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	295072	A. BUILDING _____ B. WING _____	01/16/2009

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of 24 sampled residents (#1).

Findings include:

1. Resident #1 was admitted to the facility on 1/6/09 with diagnoses including Congestive Heart Failure, Osteoarthritis, Atrial Fibrillation, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.

Resident #1 was admitted to the facility with an indwelling Foley catheter as documented on the resident's Nursing Admission Assessment form dated 1/6/09. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.

At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated if a resident with an indwelling Foley catheter was admitted to the facility, a Catheter Need Evaluation and Care Plan form was completed to determine the need for the catheter. Regional Director Consultant indicated the form also acted as the resident's care plan.

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F 279	Continued From page 2 No documented evidence a Catheter Need Evaluation and Care Plan form was completed for Resident #1. On 1/16/2009 in the afternoon, the Director of Nursing confirmed Resident #1 did not have a catheter assessment completed and no indwelling catheter care plan initiated.	F 279		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to medically justify indwelling catheter use and provide appropriate catheter care for 4 of 24 sampled residents (#1, #21, #12, #19). Finding include: 1. Resident #1 was admitted on 1/6/09 with diagnoses including Congestive Heart Failure, Osteoarthritis, Atrial Fibrillation, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. Resident #1 was admitted to the facility with an indwelling Foley catheter as documented on the resident's Nursing Admission Assessment form	F 315		

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dated 1/6/09. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.

At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated if a resident with an indwelling Foley catheter was admitted to the facility, a Catheter Need Evaluation and Care Plan form was completed to determine the need for the catheter. The Regional Director Consultant indicated the form also acted as the resident's care plan.

No documented evidence of a Catheter Need Evaluation and Care Plan form was completed for Resident #1. On 1/16/2009 in the afternoon, the Director of Nursing confirmed Resident #1 did not have a catheter assessment completed and no indwelling catheter care plan initiated.

2. Resident #21 was admitted on 12/17/2008, with diagnoses including Pneumonia, Urinary Tract Infection, Muscle Weakness, Hypertension, Severe Glaucoma, and Anxiety.

Resident #21 was admitted with a Foley catheter as documented on the Nursing Admission Assessment form dated 12/17/2008. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.

There was no documented evidence Resident #21 had an order for a Foley catheter. Resident #21's Catheter Need Evaluation and Care Plan form dated 12/17/08 documented:

-"...Change catheter and drainage per MD

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F 315	Continued From page 4 (Medical Doctor) orders..." There was no documented evidence Resident #21 had specific physician orders for Foley catheter care and maintenance. At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated physician orders were needed for Foley catheter insertions. Also, Physician orders were needed for specific care and maintenance for each resident who had an indwelling catheter. 3. Resident #12 was a 91 year-old female resident initially admitted to the facility on 12/1/07 and recently re-admitted on 1/7/09, with diagnoses including Hypertension, History of Stomach Cancer, Urosepsis, Methicillin-Resistant Staphylococcus Aureus, Bacteremia, Vancomycin-Resistant Enterococcus, Muscle Weakness, Impaired Ambulation, Chronic Obstructive Pulmonary Disease, Shortness of Breath, and Chronic Pain Syndrome. The History and Physical Examinations dated 2/19/08 and 9/3/08, contained in the resident's closed records indicated no evidence of a diagnosis which revealed a diagnosis that required an indwelling catheter. The resident had a third re-admission on 1/7/09. The Nursing Admission Assessment dated 1/7/09, indicated the resident was transferred from Valley Hospital with a Foley Catheter and no diagnosis was evident in the space provided for its use. As noted in the facility's nursing assessment,	F 315		

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F 315	Continued From page 5 when a resident is admitted with a Foley Catheter, staff are to "proceed with catheter orders and care plan development." The resident's Bowel & Bladder Assessment and Management document dated 1/7/09, indicated the resident was a possible candidate for re-training or individual training for bowel and/or bladder re-training. The two page assessment document indicated no documented evidence of the resident's current status of having an indwelling catheter. It was noted on the second page that the resident was alert and cognitively intact and the preferred mode for the resident was to be a toilet. A Physician Progress Note dated 1/8/09, indicated the resident's initial assessment included a plan to admit the resident to the facility, intravenous antibiotics, PT/OT (physical therapy/occupational therapy) evaluation and treatment to improve the patient's functional ability and independence, and nutritional support. Other documentation of the resident's plan were noted, but not readable. There was no documented evidence in the assessment which revealed any catheter orders. The resident's Interim Plan of Care indicated the word "Foley" under Bladder/Bowel Status (#6 in the plan). There was no plan of care or directions of care for staff documented in the plan of care. 4. Resident #19 was a 90 year-old female resident initially admitted on 11/12/08 and recently re-admitted on 1/8/09, with diagnoses including Depression, Dementia, Hypertension,	F 315		

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Coronary Artery Disease, Congestive Heart Failure, Muscle Weakness, Gait Impairment, Dysphagia, Symbolic Dysfunction, C. Difficile Colitis, Metabolic Myopathy, Recurrent Falls, Chronic Gastritis, Diverticulitis, Osteoarthritis, Renal Insufficiency, Hyperkalemia, Hypernatremia, and Anemia.

The current History and Physical Examination dated 1/9/09, indicated the resident was re-admitted to the facility following a transfer from Southern Hills Hospital due to chest congestion. There was no mention of the resident having an indwelling catheter and/or diagnosis which required the resident to have a catheter.

The Nursing Admission Assessment dated 1/8/09, indicated a Foley Catheter was present upon the resident's re-admission and no diagnosis was evident in the space provided for its use.

The facility's Medication Record for 1/2009, following the re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis indicated on the record which supported the use of the catheter or the actual care required.

The resident's Interim Plan of Care dated 1/8/09, indicated the word "Foley Catheter" under the "Toileting" section. However, there was no documented evidence of a plan of care or directions of care for staff documented in the plan of care.

A Physician Telephone Order dated 1/14/09, indicated an order to D/C (discontinue) Foley Catheter. This order was written following an

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F 315	Continued From page 7 interview (1/13/09) with nursing staff into the reasons why Resident #19 had an indwelling catheter.	F 315		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to serve food under sanitary conditions. Findings include: On 1/13/09, a tour of the kitchen area revealed the following deficiencies: 1. The chlorine based chemical dishwasher was tested three times for chlorine with the facilities chlorine test strips and failed to produce the minimum 50 parts per million (ppm) residual chlorine level. The chlorine test log indicated that the last chlorine test was done on 1/11/09. Note: The dishwasher service company came out to the facility and repaired the dishwasher on 1/13/09, after being brought to the attention of the facility.	F 371		

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F 371	Continued From page 8 2. Deserts for the residents in the walk-in refrigeration unit were not covered. 3. There was a broken light bulb in the walk-in refrigerator. 4. The hand wash sink by the dishwasher was not secured to the wall.	F 371		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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F 431	Continued From page 9 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure expired medications were discarded in a timely manner. Findings include: On 1/14/09 at 3:40 PM, the locked medication box in the Medication Room #1 refrigerator contained: a) a one milliliter vial of Lorazepam (2 milligrams per milliliter) with an expiration date of 11/07; b) seven one milliliter vials of Lorazepam (2 milligrams per milliliter) with an expiration date of 4/08; and c) four one milliliter vials of Lorazepam (2 milligrams per milliliter) with an expiration date of 9/08. Note: The vials with the expiration date of 4/08 were intermingled with two vials displaying an expiration date of 2011, in a small "ziplock" bag. On 1/14/09 at 3:45, Employee #1 acknowledged the vials had expired and should have been removed and discarded on the last day of the month on the label.	F 431		